AUTHORIZATION FOR RELEASE OF INFORMATION

BY PROHEALTH CARE ASSOCIATES, LLP

I hereby authorize and direct the above-named clinical practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify.

Signature____ Date ____________________

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to the above-named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

Signature____ Date ____________________

I, ____________________________________, attest that I fully understand my financial responsibility for the charges resulting from my decision to the following:

____ I chose to see an out-of-network provider (non-participating)

____ I chose to see an in-network (participating) specialist without an authorized referral from my primary care physician.

I understand that the provisions of my benefit plan will determine my financial liability:

Date of Service _______________

Signature of Patient (or Guardian) ____